Mahmoud Mohamed
1620 Stuart Street
Berkeley, CA 94703-2010
(510) 644-2159

August 20, 2007

By U.S. Mail

Honorable Magistrate Judge
Wayne D. Brazil
United States District Court
Northern District of California
Oakland CA.

WDB M

Re: *Mohamed v. Potter,* Case No. C07-03306 [redacted]

Dear Judge Brazil:

I am the plaintiff *pro se* in the above captioned case. I have been experiencing health problems and I was treated at emergency room several times on July and August, 2007, I have been scheduled for a series of medical tests over the coming weeks. I was given a case schedule when I filed the complaint. Because of my health problems I am respectfully asking the court for a 90 days extension for all of these dates. The defendant in this case, the U.S. Postal service will not be affected by this change of dates because I have not yet served them.
For your reference I am enclosing copies of medical forms that I was given at the hospital.

Respectfully submitted,

Mahmoud Mohamed

KAISER PERMANENTE®

☐ Inpatient Medical Record
☐ Outpatient Chart

KAISER ... HOSPITAL
MOHAMED, MAHMOUD
MR# 11000294294 09/27/52
Name:
IMPRINT AREA

EMERGENCY SERVICES AFTER-CARE INSTRUCTIONS

The Emergency Department (ED) gives care to patients requiring immediate medical attention. These instructions can help you get any further care that may be needed. **If the condition you were treated for worsens, if unexpected problems arise, or if you are not able to get the recommended follow-up treatment, phone or return to the Emergency Department (752-7667).**

Your diagnosis: chest wall contusion

The doctor(s) who treated you in the ED: R. Rev

☐ Please contact your regular doctor for follow-up. You should communicate with your doctor by phone or e-mail, or see them, within ______ days. Many doctors are reached easily via e-mail. You can look up your doctor's home page and send them e-mail at permanente.net/doctor

☐ An appointment has been scheduled for you in the ______________ Department with Dr. ______________ as follows: Date: __________ Time: __________

☐ A referral (eConsult) has been made for you to the ______________ Department. You should be contacted ______________. If you have not been contacted by then, please call that department.

☐ Please call the department below and make an appointment. You should be seen in about ______ days.

Please bring this sheet with you to any future appointments.

☐ Dermatology	752-1145	☐ Occupational Medicine	752-1244	☐ Psychiatry	752-1075
☐ ENT/HNS	752-1115	☐ Orthopedics	752-7484	☐ Surgery	752-1105
☐ Eye	752-1235	☐ Chemical Dependency Rehab Program (CDRP)	251-0121	☐ Urgent Care	752-1190
☐ Internal Medicine	752-1190			☐ Urology	752-6789
☐ Neurology	752-1088	☐ Pediatrics	752-1200	☐ Other: ______	
☐ Ob/Gyn	752-1100	☐ Podiatry	752-1231		

☐ The following printed instructions have been given to you: ______________

Please read them carefully now. Ask the ED staff for any further explanation before you leave.

☐ **eRx** ☐ **Paper prescription** for:

was sent to this pharmacy: ☐ Discharge ☐ Fabiola 1 ☐ ______________. You may pick it up now.

☐ Try to cut back or stop smoking completely. For more information and support, call Health Education at 752-6150.

☐ Blood pressure check within 1 week. Call your regular doctor or Urgent Care to set up an appointment.

☐ **X-ray reading in the ED is preliminary.** We'll contact you within 48 hours if the final reading changes your treatment.

☐ **Warning:** You received a drug in the ED that may cause drowsiness. Do not drive or take alcohol for the next ____ hrs.

☒ For fever/pain try ibuprofen (Motrin/Advil): 600 pills (mgs) mls tsps every 8 hrs for 3 days w/ Food!!

☐ For fever/pain try acetaminophen (Tylenol): ______ pills mgs mls tsps every ______ hrs for ______ days

☐ Return to the ED for **recheck/suture removal** in ______ hours/days.

I, the undersigned, acknowledge receipt of all the instructions checked above, with special instructions noted below.

INSTRUCTIONS ISSUED BY (PRINT NAME): Michael Rev

INSTRUCTIONS REVIEWED BY (PRINT NAME):

Special instructions: Please follow up w/ your doctor in 2-3 days or return to ER if getting worse. Be sure to take food w/ Motrin.

PATIENT OR GUARDIAN SIGNATURE: X [signature]

PHONE NUMBER:

DATE:

TIME:

KAISER PERMANENTE®

Patient Name Identification

Mahmoud Mohamed
0629 4294

IMPRINT AREA

VISIT VERIFICATION/FAMILY LEAVE Health Care Provider Certification

(This section must be completed and determined by treating provider only)

THE ABOVE NAMED PERSON:

☐ **NO**, does not have a "Serious Health Condition" (see reverse for further information) **OR**

☐ **YES**, has a "Serious Health Condition", as defined below *(check one)*:

1. ☐ Hospital stay
2. ☐ Absence plus treatment
3. ☐ Pregnancy
4. ☐ Chronic condition requiring treatment
   - ☐ Is currently incapacitated
   - ☐ Is not currently incapacitated
5. ☐ Permanent/long-term condition requiring supervision
6. ☐ Multiple treatments (non-chronic condition)

☐ Has a "Serious Health Condition" and requires a family member to take time off from work to provide basic medical, personal or safety needs, transportation, or psychological comfort. The probable frequency and duration of this need is _____

☐ Estimated date of Surgery/Procedure/Delivery: _____

☐ Diagnosis (Complete on patient request only): _____

THE ABOVE NAMED PERSON:

☑ Was seen at this office on: 8/6/7 ☐ Has been given telephone advice on: _____

☐ Has been ill and unable to attend work/school/physical education _____ through _____

☐ States he/she has been ill and unable to attend work/school/physical education _____ through _____

☑ Can return to full duties with NO RESTRICTIONS on 8/27/7 **OR**

☐ Can participate in a modified work program starting _____ and continuing to _____

(Please note: If modified work is not available, this patient is then unable to work for this time period.)

☐ Restrictions: _____ hours per day _____ hours per week

BASED ON AN 8-HOUR DAY EMPLOYEE CAN:

stand/walk	_____ minutes per hour	_____ total hours	☐ no restrictions
sit	_____ minutes per hour	_____ total hours	☐ no restrictions
drive	_____ minutes per hour	_____ total hours	☐ no restrictions

LIFT/CARRY (Occasionally = up to 1/3 workday. Frequently = up to 2/3 workday):

0-10 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
11-25 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
26-40 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

Can lift/carry up to _____ **lbs.**

EMPLOYEE IS ABLE TO:

bend	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
squat	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
kneel	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
climb	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
reach above shoulders	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
perform repetitive hand motions	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

ASSISTIVE DEVICES? (e.g., cast, brace, crutches) _____

RESTRICTIONS: _____

OTHER: _____

TREATMENT PLAN: _____

☐ Medication effects which could impair performance: _____

☐ Physical therapy required. Frequency: _____

NOTE: If patient is Industrial, physician signature is REQUIRED.

SIGNATURE AND TITLE: [signature] MD — DATE: 8/6/7

NAME (PRINT): Morrahe — LOCATION/ADDRESS — PHONE

KAISER PERMANENTE

☐ Inpatient Medical Record
☐ Outpatient Chart

KAISER FOUNDATION HOSPITAL
MOHAMED, MAHMOUD
MR# 11000629429 4
09/27/58
NO

Direct A-to ED Reception After O/C copay

EMERGENCY SERVICES AFTER-CARE INSTRUCTIONS

IMPRINT AREA

The Emergency Department (ED) gives care to patients requiring immediate medical attention. These instructions can help you get any further care that may be needed. **If the condition you were treated for worsens, if unexpected problems arise, or if you are not able to get the recommended follow-up treatment, phone or return to the Emergency Department (752-7667).**

Your diagnosis: chest pain, fatigue

The doctor(s) who treated you in the ED: Marek

☒ Please contact your regular doctor for follow-up. You should communicate with your doctor by phone or e-mail, or see them, within 7 days. Many doctors are reached easily via e-mail. You can look up your doctor's home page and send them e-mail at permanente.net/doctor

☐ An appointment has been scheduled for you in the _____ Department with Dr. _____ as follows: Date: _____ Time: _____

☒ A referral (eConsult) has been made for you to the Cardiac Lab Service Department. You should be contacted Monday. If you have not been contacted by then, please call that department.

☐ Please call the department below and make an appointment. You should be seen in about _____ days.

Please bring this sheet with you to any future appointments.

☐ Dermatology	752-1145	☐ Occupational Medicine	752-1244	☐ Psychiatry	752-1075
☐ ENT/HNS	752-1115	☐ Orthopedics	752-7484	☐ Surgery	752-1105
☐ Eye	752-1235	☐ Chemical Dependency	251-0121	☐ Urgent Care	752-1190
☐ Internal Medicine	752-1190	Rehab Program (CDRP)		☐ Urology	752-6789
☐ Neurology	752-1088	☐ Pediatrics	752-1200	☐ Other: _____	
☐ Ob/Gyn	752-1100	☐ Podiatry	752-1231		

☒ The following printed instructions have been given to you: Cardiac lab services

Please read them carefully now. Ask the ED staff for any further explanation before you leave.

☐ **eRx** ☐ **Paper prescription** for:

2007 JUN 22 PM 5:39

_____ was sent to this pharmacy: ☐ Discharge ☐ Fabiola 1 ☐ _____. You may pick it up now

☐ Try to cut back or stop smoking completely. For more information and support, call Health Education at 752-6150

☐ Blood pressure check within 1 week. Call your regular doctor or Urgent Care to set up an appointment.

☒ **X-ray reading in the ED is preliminary.** We'll contact you within 48 hours if the final reading changes your treatment

☐ **Warning:** You received a drug in the ED that may cause drowsiness. Do not drive or take alcohol for the next ____ hrs

☐ For fever/pain try ibuprofen (Motrin/Advil): ____ pills mgs mls tsps every ____ hrs for ____ days

☐ For fever/pain try acetaminophen (Tylenol): ____ pills mgs mls tsps every ____ hrs for ____ days

☐ Return to the ED for **recheck/suture removal** in ____ hours/days.

I, the undersigned, acknowledge receipt of all the instructions checked above, with special instructions noted below

INSTRUCTIONS ISSUED BY (PRINT NAME): Mark

INSTRUCTIONS REVIEWED BY (PRINT NAME): [illegible]

Special instructions: Take asprin 81 mg daily

PATIENT OR GUARDIAN SIGNATURE: X [illegible]

PHONE NUMBER

DATE: 6/23/07

TIME: 02 Am

DISTRIBUTION: WHITE - PATIENT • YELLOW - [illegible]

KAISER PERMANENTE®

East Bay Medical Center
☐ Oakland ☐ Richmond
☐ Inpatient ☐ Outpatient

06294294

MR# 06294294
DOB 09-27-1952 M R
MOHAMED,MAHMOUD,,

32525407

RELEVANTS EXIST
REQ#32525407

PATIENT CONSENT FOR COMPUTERIZED TOMOGRAPHY (CT) WITH IV CONTRAST DYE

Your doctor has referred you for a computerized t(study in which images of the body are generated by a compute... injected into a vein. This is done to produce more detail for interpretation.

The majority of patients tolerate the injection well and experience no unusual side effects. It is not uncommon for patients to experience a warm flushing sensation, a metallic taste, or nausea during the injection. In rare instances, allergic reactions to the injection may occur. The vast majority of these reactions are mild and typically consist of itching, hives, redness, or mild shortness of breath.

An uncommon complication of IV contrast can be a decrease in kidney function. The use of Metformin (also known as Glucophage, Glucovan, Metaglip, or Avandamet) is contraindicated in patients with poor renal function because of the rare but potentially fatal side effect of lactic acidosis. The medical recommendation is that Metformin (Glucophage, Glucovan, Metaglip, or Avandamet) be stopped at the time of IV contrast administration and not resumed until normal kidney function is documented. Your doctor is aware of these possible complications but is of the opinion that the diagnostic information which your CT scan will provide outweighs the above noted risk.

An alternative to CT with IV contrast can include noncontrast CT, MRI scan, or ultrasound in some circumstances.

If you have any questions concerning the procedure, our staff will be happy to answer them, either before or at the time of the study.

Please complete the following questions (To be completed by patient):

- Possibility of pregnancy: ☒ Not applicable ☐ No ☐ Yes Last Menstrual Period: _____
- Are you breastfeeding? ☒ Not applicable ☐ No ☐ Yes

Have you ever had an allergic reaction to contrast dye? ☒ No ☐ Yes
If yes, please describe: _____

- Allergies (any type): ☐ No known allergies ☐ Iodine allergy ☐ Other allergies (list): Penicillin
- Diabetes: ☐ No ☒ Yes Heart Disease: ☐ No ☒ Yes Kidney Problems: ☒ No ☐ Yes
  Myeloma: ☒ No ☐ Yes Asthma: ☒ No ☐ Yes
- Are you currently taking Metformin (also known as Glucophage, Glucovan, Metaglip, or Avandamet) for Diabetes? ☐ No ☐ Yes
- Since your physician referred you for this CT scan, has there been any change to the medications you currently take? ☐ No ☐ Yes (list): _____

Risks and benefits of this procedure were discussed with me as described above.

X _____ _____ _____
PATIENT OR GUARDIAN SIGNATURE DATE TIME

_____
PARENT OR GUARDIAN RELATIONSHIP TO PATIENT

_____ _____ _____
WITNESS SIGNATURE DATE TIME

KAISER PERMANENTE®

LABORATORY REQUISITION
General Procedures

PATIENT INFORMATION

Alameda Medical Offices

☐ AZEBU	64073	☑ MARRAMA	80548
☐ CHAN	57488	☐ MINGER	86786
☐ CHENG	54977	☐ NGUYEN	19599
☐ CHU	13642	☐ RAHIM	57065
☐ COHEN	16672	☐ RUIZ	20607
☐ COSCA	83793	☐ SHUN	89653
☐ CRANEY	89456	☐ TINDER	16810
☐ LAW	15874	☐ TRONCOSO	16661
☐ LONGWELL	16662	☐ TSO	54960

Physician's Name: _____

Other MD: _____

PRIORITY
Collection, processing and reporting will be routine unless checked below.

ME ☐ Life-Threatening
EX ☐ ASAP
PW ☐ Patient waiting
AM ☐ Morning draw
TS ☐ Draw at

Date: _____ Time: _____

ROOM NO.

COMMENTS

☐ R/O _____ ☐ PE _____
☐ Hx of _____ ☐ Pre-emp _____
☐ Follow Up _____ ☐ Day of Cycle _____
☐ Prev. result _____ ☐ LMP _____
☐ Rx _____ ☐ Do _____ before appt.
☐ Sample # _____

PRINT WITH RESULTS:
☐ Call Patient
☐ Non-fasting
☑ Fasting 10 hrs.

PATIENT TYPE / CHART LOCATION
LOC _____ ☐ Inpatient ☐ Emergency Dept.
☐ Pre-op Fac: _____ Date of surgery: _____
☐ Pre-admit Fac: _____ Date of admit: _____
☐ Prenatal ☐ Premarital ☐ Industrial
☐ **COPY REPORT TO:** _____

INSTRUCTIONS TO LAB / PATIENT
Mid September 07

CHEMISTRY

☑ Sodium	NA	☐ Magnesium	MG	☐ Neonate T. Bilirubin	BILITN	☑ Lipid Panel–fasting (LDL, CHOL, HDL, TRIG)	LIPID
☑ Potassium	K	☐ Uric Acid	URIC	☐ Alk Phos	ALKP	☐ Cholesterol	CHOL
☑ Creatinine	CREAT	☐ Albumin	ALB	☐ Amylase	AMYL	☐ HDL	HDL
☑ GFR	GFR	☐ Serum Protein Elect.	PEP	☑ ALT (SGPT)	ALT	☐ Triglycerides–fasting	TRIG
☐ BUN	BUN	☐ Ferritin	FERR	☐ AST (SGOT)	AST	☐ LDL–non-fasting	LDLDIRECT
☑ Glucose – fasting	GLUCF	☐ Iron/TIBC	IRON/TIBC	☐ LDH	LD	(For LDL–fasting, order Lipid)	
☐ Glucose – random	GLUCR	☐ Hgb Electrophoresis	HGBNPSCR	☐ Troponin I	TROP I	Indicate desired LDL Goal:	
☑ Hemoglobin A_1C	HGBA1C	☑ TSH	TSH	☐ CKMB–cardiac	CKMB	☐ LDL Goal < 160	G160
☐ Fructosamine	FRU/ALB	☐ Free T4 analog	T4F AN	☐ CK	CK	☐ LDL Goal < 130	G130
☐ Carbon Dioxide	CO_2	☐ PSA	PSA	☐ Homocysteine	HOMOC	☐ LDL Goal < 100	G100
☐ Chloride	CL	☐ Serum Pregnancy	PREGS	☐ CRP–High Sensitivity	CRPHS	☐ LDL Goal < 70	G70
☐ Calcium	CA	☐ Quant. Beta HCG	BHCG				
☐ Phosphorus	PHOS	☐ Total Bilirubin	BILIT				

SEROLOGY

☐ RPR (VDRL)	RPR	☐ Hep A IgM (Acute)	HAM	☐ Rubella	RUB
☐ Mono	MONO	☐ Hep A IgG (Immunity)	HAG	☐ Rubeola	RUBEO
☐ ANA	ANA	☐ Hep B Surface Ag (Acute or chronic)	HBSAG	☐ Varicella	VARZ
☐ Rheumatoid Factor	RA	☐ Hep B Core Ab (Pre-vaccine)	HBCAB	☐ CMV	CMV
☐ CRP (C-Reactive Protein)	CRP	☐ Hep B Surface Ab (Immunity)	HBSAB	☐ H. pylori	HPY
☐ Blood Group, Rh	ABORH	☐ Hepatitis C Antibody	HCAB	☐ Mumps	MUMPS
☐ Antibody Screen	ABSC			☐ Toxoplasma	TOXO
☐ Direct Coombs	DAT			☐ Lyme	LYME

BLOOD GASES

Includes pH, pCO_2, pO_2, HCO_3, BE, O_2Sat

Temp °F _____
FIO_2% _____ ☐ Room Air

☐ Arterial	ABG
☐ Venous	VBG
☐ Capillary	CBG
☐ Arterial–Cord blood	ABG CB
☐ Venous–Cord blood	VBG CB
☐ Carbon Monoxide Oximetry	CO OX

HEMATOLOGY

☐ Hemoglobin Hematocrit	HH
☑ CBC (w/o Differential)	CBC
☐ CBC with Differential	CBCD
☐ Reticulocyte Count	RETIC
☐ Westergren Sed Rate	ESR
☐ Hematocrit, Manual	HCTM

URINALYSIS

☐ Clean catch	UA
☐ Catheter	
☐ Menstruating	
☐ Urine Microscopic required	UM
☐ Culture per protocol	
☐ Urine Pregnancy	PREGU
☑ Urine Microalbumin	U MICROALB
☐ Urine Prot / Creat Ratio	U PROTCREA

COAGULATION

Indicate Anticoagulant Therapy

☐ None
☐ Warfarin
☐ Heparin (Circle type)
Continuous Intermittent LMW
☐ _____

Last Dose:
Date: _____
Time: _____

☐ Prothrombin Time INR	PT
☐ Activated PTT	APTT
☐ Fibrinogen	FIBR
☐ Fibrin Split Products	FSP
☐ D-Dimer	DDIMER
☐ _____	
☐ _____	
☐ _____	

TOXICOLOGY / DRUGS

☐ Peak ☐ Trough ☐ Random

Last Dose:
Date: _____
Time: _____
Dose: _____

☐ Vancomycin	VANCO
☐ Gentamycin	GENT
☐ Tobramycin	TOBRA
☐ Theophylline	THEO
☐ Phenytoin	PHTN
☐ Carbamazepine	CARB
☐ Phenobarbital	PHENO
☐ Digoxin	DIG
☐ Valproic Acid	VALP
☐ Salicylate	SAL
☐ Acetaminophen	ACETA
☐ Ethanol (local)	ETOH

DRUGS / OTHER

☐ Cyclosporine	CYCLO
☐ FK 506 (Prograf)	FK506
☐ Methotrexate	METHO
☐ Procainamide/NAPA	PROC
☐ Lithium	LI
☐ Quinidine	QUIN
☐ _____	
☐ _____	
☐ _____	
☐ _____	
☐ _____	
☐ _____	
☐ _____	

Patient Letter: ☑ English ☐ Spanish

DATE & TIME RECEIVED

APPOINTMENT REMINDER

You are scheduled to see:

Dr. Ruby OEHM

On: Tuesday July 17th

Time: 1:30 pm

In Cardiology Clinic
Hospital Building 2nd Floor

Register at the Med 8/Cardiology
Reception Desk
2nd Floor Hospital Building
prior to your appt.

KAISER PERMANENTE
OAKLAND

CARDIOLOGY

DEPARTMENT

KAISER OAKLAND
280 WEST MACARTHUR BLVD.
OAKLAND, CA 94611
752-6474

KAISER PERMANENTE

CARDIOLOGY CLINIC

You have been referred to the Cardiology Clinic by your Primary Care Physician. **(this may be a one – time consultation or require more visits.)** The cardiology consultant does not take the place of your primary care physician who coordinates all of your care.

DIRECTIONS TO CLINIC

Cardiology Clinic is located on the second floor of the hospital tower. Enter the Hospital Building at the East Entrance on Howe Street. Up the stairs to the first floor and turn left, pass the hospital pharmacy, & take the corner elevator (Elevator C) to the 2nd floor. Register at the Medicine Station 8/9 reception desk, then go to the Cardiology Clinic which is the second medical station down the hallway.

YOUR APPOINTMENT

Bring a list of questions/concerns for the doctor.
Bring all of your medications, including over the counter and herbal medications.

TO CONTACT CARDIOLOGY

Your primary doctor will continue to be your primary medical care giver. The primary care physician is the main coordinator of your care thru the specialty clinics. Any medical problems that you have should still be addressed to his/her office. To leave a message, or to make an appt. with your primary doctor, call #752-1190. Your Primary MD may also be the one who will be reordering your cardiac medications.

CARDIOLOGY PHONE NUMBERS

Cardiology telephone number is 752-6474.
Option #1 Medication refill
#2 Make or cancel an appt
#3 Returning a call or to leave a message for the cardiologist, or to speak to the advice nurse.
#4 Directions to cardiology, Oakland Medical Center or for treadmill instructions.

If you are having severe chest pain, shortness of breath, or if the pain you are feeling is the same as when you were diagnosed with a heart attach, call 911 or have someone drive you to the Emergency Room.

FORMS

All forms or letters to be written go to Medical Secretaries … They will do appropriate paper work and get physician's signature.
Medical Secretaries are located on the ground floor of the hospital building.

CARDIOLOGY ADVICE RN

To speak to an advice nurse in cardiology for **non urgent matters**, call 752-6474, option #3. State your name, medical record number , call back telephone number and a short message. **If you are having severe chest pain, short of breath or feel you have an emergency do not call cardiology… call 911 or go to emergency room.** This number is for non emergency calls only.
After 4:30pm or on the week-ends/holidays call 752-1190, the call center, with any urgent problems, or for advice.

If you have valve disease or have had valve surgery and have a dental appointment, call the cardiology advice nurse at 752-6474 option #3, to determine whether you need to take antibiotics prior to the procedure.

TO SCHEDULE:

Echo : 752-6440
Treadmill: 752-6440
Holter Monitor: 752-6474
Event Monitor: 752-6440